PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION (X3) D.		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
155121		B. WING		02/28/2013	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	C		NION ST	
ROSEWA	ALK VILLAGE AT L	AFAYETTE	LAFAY	ETTE, IN 47904	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	T	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000			-		
1 0000					
	This visit was f	or the Investigation of	F0000		
		00122053 and IN	1 0000		
	00124506.	00 122033 and IN			
	00124506.				
		-h INIO0400050			
	•	nber IN00122053			
		d, due to lack of			
	evidence.				
	Complaint num	nber IN00124506			
	unsubstantiate	d, due to lack of			
	evidence.				
	Unrelated defic	ciencies are cited.			
		sicroics are offed.			
	Survey Dates:	February 27 and 28,			
		rebluary 21 and 20,			
	2013				
	- "	000054			
	Facility number				
	Provider numb				
	AIM number: 1	100275490			
	Survey Team:				
	Rita Mullen RN	I, TC			
	Bobette Messn				
	Census Bed ty	pe:			
	SNF/NF: 105	r			
	SNF: 14				
	Total: 119				
	10tal. 119				
	0	4 0 mm = 0			
	Census Payor	type:			
	Medicare: 32				
	Medicaid: 76				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

000051

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155121	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE		1903 UI	ADDRESS, CITY, STATE, ZIP CODE NION ST ETTE, IN 47904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	Other: 11 Total: 119			
	Sample: 4 Supplemental: 6			
	This deficiency reflects state findings cited in accordance with 410 IAC 16.2.			
	Quality Review was completed by Tammy Alley RN on March 6, 2013.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z0UQ11

Facility ID: 000051

If continuation sheet

Page 2 of 5

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155121		A. BUILDING 00			COMPLETED 02/28/2013		
155121 B.			B. WING				2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE NION ST		
ROSEWALK VILLAGE AT LAFAYETTE				ETTE, IN 47904			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	ETC POLICIES The facility must over written policies are mistreatment, near residents and mister property. Based on reconsinterview, the fact their policy for a sinvestigation, and administrator into report the ablindiana State Elevithin 24 hours (Resident F) Findings include During an interion 2/27/2012 and indicated that the concern to CNA was verbally abronomate. Reconcern to CNA indicated CNA CNA #1 would care for her and future. During an interior Nursing (DO)	acility failed to follow abuse prevention, and reporting an ouse to the immediately and failed ouse allegation to the Department of Health of the event. The example of the event of the e	F02	26	This campus respectfully requests a desk review for this survey: What corrective actions will be accomplished for those residents found to have been affected by the deficient practic Resident F's roommate had not negative adverse reactions and no negative psycho-social distress from the allegation. Resident F's roommate had a skin assessment completed with no findings. A pain assessment was completed with no finding Social Serivce followed up with both residents with no negative psycho-social findings. All allegations of abuse will be investigated and reported to the ISDH within 24 hours by the executive director or designeeResidents and familie have been encouraged to report any allegation of abuse to any of the staff for investigation and they will notify the executive directorHow other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken? All reside have the potential to be affected No other residents well affected No other residen	ce? od/or full tth at s. n e es ort one d	03/30/2013
	9:30 a.m., a co	ppy of the abuse			affectedNo other residents well affectedAll allegations of abuse		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z0UQ11

Facility ID: 000051

If continuation sheet

Page 3 of 5

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155121	B. WIN			02/28/2	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					NION ST		
ROSEWALK VILLAGE AT LAFAYETTE					ETTE, IN 47904		
ROSEW	ALK VILLAGE AT L	AFATETTE		LAFATI	ETTE, IN 47904		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	allegation inve	stigation was			will be investigated and report		
	requested.				to the ISDH within 24 hours by	′	
					the executive director or		
	During an inter	view with the Director			designeeResidents and familie		
	_	2/28/2013 at 9:45 a.m.,			have been encouraged to repo		
	_				any allegation of abuse to any of the staff for investigatoin an		
		he abuse investigation			they will notify the executive	~ 	
		she was not aware of			directorWhat measures will be		
	1	gation made by			put into place to ensure the		
	Resident F.				deficient practice does not rec	ur?	
					All allegations of abuse will be		
	During an inter	view with the Executive			investigated and reported to the	ne	
	•	28/2013 at 10:50 a.m.,			ISDH within 24 hours by the		
		she had sent the			executive director or		
					designeeResidents and familie		
		of abuse allegation to			have been encouraged to repo		
	•	artment of Health on			any allegation of abuse to any		
		e further indicated she			of the staff for investigatin and they will notify the executive		
	was advised of the abuse allegation				director. Campus staff will be		
	report on 02/28/2013.				inserviced and		
					ED/DNS/Designees will condu	ıct	
	A facility policy	for "Abuse Prohibition,			interviews of all interviewable		
		I Investigation" (not			residents using the QIS questi	ons	
	dated) receive	• ,			related to abuse to ensure all		
	,				allegations or concerns are		
		on 2/28/2013 at 1:15			reported and handled according	~	
	p.m., indicated	the following:			to policy. All allegations will be	;	
					reported immediatley to the		
	"5. All abuse	allegations must be			ED/DNS. Management staff w initiate a full investigation per		
	reported to the	Executive Director			facility policy. Staff on all shifts		
		nd to the resident's			will be interviewed to ensure s		
	_	(sponsor, responsible			understand allegations of abus		
		4 hours of the report.			and the timely reporting of abu		
	Failure to repo				allegations to the ED/DNS. Ho		
					the corrective actions will be		
		tion, up to and including			monitored to ensure the deficie		
		nination7. The			practice will not recur?Executive		
	Executive Dire	ctor/ designee will			director or designee will rando	-	
	report all unus	ual occurrences, which			interview staff members about		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z0UQ11

Facility ID: 000051

If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155121	A. BUILDING	00	COMPLETED 02/28/2013
	133121	B. WING	DEGG CHTW CTATE TIE CORE	02/20/2013
ROSEW	PROVIDER OR SUPPLIER ALK VILLAGE AT LAFAYETTE	1903 UNIC	DRESS, CITY, STATE, ZIP CODE DN ST TE, IN 47904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	included allegations of abuse, within 24 hours of discovery, to the Long Term Care Division of the State of Indiana Department of Health" 3.1-28(a)	al w cc al m qu th by cc ac er di th im to w fo 3. re ov di or A	buse policies and procedure reekly for 4 weeks using the ontinuous quality improveme buse - staff interview tool, the nonthly for 3 months, then wartely times 3. The results of nese interviews will be review by the CQI committee oversety the executive director. If 10 ompliance is not achieved an action plan will be developed to the sure compliance. Executive director or designee will compine continuous quality mprovement abuse prohibition of with any allegations of abuse welly for 4 weeks, then monto a months, then quarterly times. The results of this will be eviewed by the CQI committee everseen by the executive irrector. Compliance will be 10 or action plan will be developed all allegations of abuse will be exported within 24 hours to the SDH.	nt en of yed en o0% n use ttlhy mes ee

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z0UQ11

Facility ID: 000051

If continuation sheet

Page 5 of 5